CHAPTER 4: RECOMMENDED HIV PREVENTION INTERVENTIONS

Introduction

For more than twenty-five years in South Carolina, HIV prevention providers have used a variety of methods in attempting to control the HIV epidemic. Although local providers share a broad common goal, they have chosen many different routes to achieve it. They have taught high-risk persons how to reduce their risks of infection and about the importance of knowing their HIV status by getting tested. HIV test providers have emphasized that those who know they are HIV positive can access early treatment and care as well as engage in behaviors that will prevent transmission of HIV to others. Health communication/public information initiatives have raised the awareness of policy makers and other community leaders. These initiatives have utilized the mass media and the Internet, supported abstinence programs among youth and others, promoted condom use among sexually active adults and involved individuals in providing peer education.

HIV prevention refers to all of those varied activities designed to encourage and enable people to take action to prevent the spread of HIV infection. The definition is deliberately broad while acknowledging the wide scope of activities involved in changing behaviors of those at risk and the integral relationships among prevention, education and associated social and political factors.

In 2003, CDC announced a new initiative, *Advancing HIV Prevention (AHP)*, as a framework for interventions and strategies at the federal, state and community levels. Among these strategies are putting a "number one" priority emphasis on prevention efforts with persons living with HIV, as well as a priority on increasing opportunities for HIV testing in physicians' care settings and in community based sites. Additionally, *AHP* provides guidance for prevention interventions with identified high-risk negative persons, including usage of CDC's *Compendium of HIV Interventions with Evidence of Effectiveness* (updated through mid-2009). Interventions listed in the *Compendium* are disseminated nationwide through the *Diffusion of Effective Behavioral Interventions* (*DEBI*) project. This chapter presents choices of interventions including many from *AHP*, the *Compendium*, and *DEBI* that will help local providers realize their goals.

Deciding Whom To Target

Issues to consider when determining who should receive HIV prevention interventions include:

- Priority consideration is given to delivering services to persons living with HIV/AIDS (PLWHA), SC's and the nation's "number one" priority population.
- If not delivering services to PLWHA, then providers should work with a population that corresponds to another priority population noted in this SC HIV Prevention Plan.
- Proportion of priority population in local area that engages in specific risk behaviors (especially if population is defined by race, ethnicity, or other non-risk related identifier).
- Culture and norms of the particular priority population in local area.
- Predominant language(s) of that population in local area.
- Education and literacy of the priority population in local area.
- Competing economic or social needs of the priority population.
- Predominant media channels used to reach this population in area.

Intervention Categories and Definitions

CDC classifies categories of interventions as shown in Table 1 with their definitions.

Table 1: Intervention Categories and Definitions
Health Education and Risk Reduction (HE/RR)
---Individual Level Intervention (ILI) Intervention with a skills component provided to one person at a time.
---Group Level Intervention – (GLI) Intervention with a skills component provided to more than one person at a time.
---Community Level Intervention (CLI) Activities that attempt to improve risk conditions, affect systems, and/or influence norms in a *specific community* of persons with identified shared risk behaviors for HIV infection --- and which may also be defined by race/ethnicity, gender or sexual orientation.
---Outreach (OUT), including Internet Outreach (I-OUT) Face-to-face or Internet-based interventions with high-risk individuals conducted in places or on websites where those individuals meet. Outreach is conducted for the purpose of recruiting clients into CTR, CBCT, CRCS, and other prevention or care services, as needed, as well as for the distribution of risk reduction supplies in the face-to-face settings.
Health Communication/Public Information (HC/PI) The delivery of HIV prevention messages through one or more channels (in person to large groups, through print materials, on hotlines, on the radio or television, via the Internet) to target audiences.
Counseling, Testing & Referral (CTR) Services, including Community Based Counseling & Testing (CBCT) HIV counseling and testing delivered in public health department sites and community-based (i.e., non public health department) settings in order to increase the numbers of persons who know their HIV status and, if positive, then can be linked into care and prevention services.
Partner Services (PS) A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.
Comprehensive Risk Counseling and Services (CRCS) Client-centered, intensive, long-term, prevention-based, comprehensive counseling conducted with HIV positive persons or high risk negative persons for the purpose of preventing HIV transmission from self to others or personal avoidance of HIV infection or repeat infection.
Capacity Building (CB) Activities for strengthening the public health HIV prevention infrastructure for systems to ensure the quality of services, improve the ability to assess community needs and provide technical assistance in all aspects of program planning and operations.
Social Networking Strategies (SNS) Community-based strategies used to identify persons with undiagnosed HIV infection within various networks and link them to medical care and prevention services.

Questions to Consider in Choosing Program Interventions

In light of the previously mentioned national initiative, *Advancing HIV Prevention* (*AHP*), the following four major areas of emphasis need to be considered. Those are: 1) Incorporate HIV testing as a routine part of care in traditional medical settings; 2) Implement new models for diagnosing HIV infections outside medical settings; 3) Prevent new infections by working with people living with HIV/AIDS and their partners; and 4) Further decrease mother-to-child HIV transmission. Although the HPC and the CDC recognize the contribution of programs that have not yet received rigorous evaluation, the redoubling of prevention efforts has led to the need to place a premium on programs with evidence of effectiveness for reducing behaviors associated with HIV transmission. CDC's *Compendium of HIV Interventions with Evidence of Effectiveness* is a primary resource for proven, effective interventions. Additionally, interventions identified through the *Replicating Effective Programs* project and disseminated through the *Diffusion of Effective Behavioral Interventions* (*DEBI*) project represent the best currently available science related to HIV prevention.

In a review of these resources, providers should consider the following before selecting an intervention:

- ❑ Who should I target? (See page 4.1, *Deciding Whom To Target*)
    - Who is most in need?
    - Who is currently being served with what levels and types of programs and resources?
    - What are the gaps in intervention services?
- ❑ What are the intervention's resource requirements (ideal staffing patterns; materials needed)?
- ❑ What are my agency's resources (existing and feasibly acquired)?
- ❑ What is a particular intervention's complexity and implementation timeframe?
- ❑ What types of recruitment activities will be required to implement the intervention?
- ❑ What are the ideal physical settings and characteristics for implementing the intervention?
- ❑ What is a particular intervention's adaptability?
- ❑ What are the particular cultural, legal, ethical and political considerations in my agency and community as they relate to a particular intervention for a particular population?
- ❑ What are the necessary quality assurance measures that must be followed?
- ❑ How will I know if I am successful with a particular intervention?
    - What will be the required monitoring and evaluation data to be collected?
    - Does my agency have the capability to fully collect this data to determine the effectiveness of this intervention?

Upon completion of an intervention plan analysis such as the one just noted, the most appropriate strategies or interventions may be selected from the following table. The interventions listed represent the consensus recommendations of the S.C. HIV Panning Council as reviewed by the HPC's Prevention Committee and presented originally for consideration at the June 16, 2009 HPC meeting. Subsequent updates to the interventions list were made in 2010 and 2011; the current recommendations follow.

Table 2: HIV Prevention Priority Populations and Recommended Interventions[1] 2010 – 2014 With Special Considerations for South Carolina *Updated as of August 30, 2011*	
Priority Populations (ranked)	**Recommended Interventions (not ranked)**
1. Persons Living With HIV/AIDS (PLWHA)	▪ *Fundamentals of Prevention Counseling* (FoPC) ▪ *Project RESPECT* ▪ *Comprehensive Risk Counseling and Services* (*CRCS*)[2] ▪ *CLEAR*[3] ▪ *Healthy Relationships* ▪ *Women Involved in Life Learning from Other Women (WiLLOW)*[4] ▪ *Community PROMISE*[5] ▪ Outreach using portions of *Popular Opinion Leader* or *FoPC* as a model. ▪ Internet Outreach[6] ▪ Social Networking Strategies[7] ▪ Partner Services[8]
2. African American Men who Have Sex with Men (AAMSM)	▪ *Fundamentals of Prevention Counseling* (FoPC) ▪ *Project RESPECT* ▪ *CRCS*[2] ▪ *Many Men, Many Voices* (*3MV*) ▪ American Red Cross *Talking Drums* ▪ *Popular Opinion Leader* (*POL*) ▪ *D-Up: Defend Yourself*[9] ▪ *Community PROMISE*[5] ▪ Outreach including Internet Outreach[6] ▪ Counseling, Testing and Referral (CTR) Services[10] ▪ Social Networking Strategies[7] ▪ Partner Services[8]
3. African American Women who Have Sex with Men (AAWSM)	▪ *Fundamentals of Prevention Counseling* (FoPC) ▪ *Project RESPECT* ▪ *CRCS*[2] ▪ *Sister to Sister*[11] ▪ *SISTA* ▪ *VOICES* ▪ American Red Cross *Talking Drums* ▪ *Sisters Informing, Healing, Living, and Empowering (SiHLE*[12] ▪ *Project START* ▪ *POL* ▪ *Real AIDS Prevention Project (RAPP)* ▪ *Community PROMISE*[5] ▪ Outreach including Internet Outreach[6] ▪ CTR Services[10] ▪ Social Networking Strategies[7] ▪ Partner Services[8]

4. African American Men who Have Sex with Women (AAMSW)	▪ *Fundamentals of Prevention Counseling* (FoPC) ▪ *Project RESPECT* ▪ *CRCS*[2] ▪ *VOICES* ▪ American Red Cross *Talking Drums* ▪ *Nia*[13] ▪ *Project START* ▪ *POL* ▪ *Community PROMISE*[5] ▪ Outreach including Internet Outreach[6] ▪ CTR Services[10] ▪ Social Networking Strategies[7] ▪ Partner Services[8]
5. White Men who Have Sex with Men (WMSM)	▪ *Fundamentals of Prevention Counseling* (FoPC) ▪ *Project RESPECT* ▪ *CRCS*[2] ▪ *POL* ▪ *Mpowerment* ▪ *Community PROMISE*[5] ▪ Outreach including Internet Outreach[6] ▪ CTR Services[10] ▪ Social Networking Strategies[7] ▪ Partner Services[8]
6. Injecting Drug Users (IDUs)	▪ *Fundamentals of Prevention Counseling* (FoPC) ▪ *Project RESPECT* ▪ *CRCS*[2] ▪ American Red Cross *Talking Drums* ▪ *Study to Reduce Intravenous Exposures (STRIVE)*[14] ▪ *Safety Counts* ▪ *POL* ▪ *Community PROMISE*[5] ▪ Outreach including Internet Outreach[6] ▪ CTR Services[10] ▪ Social Networking Strategies[7] ▪ Partner Services[8]
7. Hispanics/Latinos	▪ *Fundamentals of Prevention Counseling* (FoPC) ▪ *Project RESPECT* ▪ *CRCS*[2] ▪ *VOCES* ▪ *Salud, Educacion, Prevencion y Autocuidado (SEPA)* ▪ *SISTA-adapted for Latinas*[15] ▪ *Take Care of Yourself* ▪ *POL* ▪ *Community PROMISE*[5] ▪ Outreach including Internet Outreach[6] ▪ CTR Services[10] ▪ Social Networking Strategies[7] ▪ Partner Services[8] ▪ Health Communication/Public Information

Special Considerations for South Carolina
[1]Interventions Guidance: ▪ *Provisional Procedural Guidance for Community-Based Organizations*: http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance.htm ▪ *Compendium of HIV Interventions with Evidence of Effectiveness*: http://www.cdc.gov/hiv/resources/reports/hiv_compendium/index.htm; ▪ *Replicating Effective Programs Plus*: http://www.cdc.gov/hiv/topics/prev_prog/rep/index.htm; ▪ *Diffusion of Effective Behavioral Interventions (DEBI) Project*: http://www.effectiveinterventions.org/
[2] CRCS: An intensive, individual level, client-centered risk reduction intervention for people at high risk for HIV infection or transmission. http://www.cdc.gov/hiv/topics/prev_prog/CRCS/index.htm
[3]CLEAR: The intervention is labor intensive and may not be suitable for use in the designed format. Certain components may be suitable for use but would be considered adaptation if not implemented the way it was intended. Staff need to be a licensed MSW or Counselor. Staff must be specifically employed to deliver the intervention. Clients need to be high functioning and dedicated to completing the intervention for it to be successful. This intervention works better with students who attend high school and college. Components of this intervention can be integrated with CRCS. Agency readiness is important because it depends on agency funding due to facilitator needing to be a licensed therapist or clinical social worker.
[4]WiLLOW: This intervention is for heterosexual women, regardless of race or ethnicity, living with HIV/AIDS who are 18 – 50 years of age and who have known their HIV serostatus for at least six months. Organizations implementing WiLLOW should utilize two facilitators, one of which must be HIV+ who has been trained in the WiLLOW curriculum. Due to the cost of this program, agencies should seek outside funding sources.
[5]Community PROMISE: Funding needs to be secured outside of DHEC to fully support the budget for the intervention. There also needs to be specific dedicated staff to successfully conduct the intervention to ensure effectiveness and fidelity to the intervention. PROMISE has been considered for use in S.C. priority populations older than the currently prioritized age demographic. More research is needed on whether it can be used with older adults (beyond the current upper age limits of the priority populations).
[6]Internet Outreach: Uses *National Guidelines for Internet-based STD and HIV Prevention: Accessing the Power of the Internet for Public Health*: http://www.ncsddc.org/upload/wysiwyg/documents/IG-FINAL.pdf. There should be flexibility in Internet outreach to include length of the online sessions sometimes in excess of the standard of five to ten minutes per session.
[7] Social Networking Strategies: A Community-Based Strategy for Identifying Persons with Undiagnosed HIV Infection. http://www.cdc.gov/hiv/resources/guidelines/snt/index.htm
[8] Partner Services: Services offered to persons with HIV and other STDs and their sexual or needle-sharing partners. Services include identifying infected persons and confidentially notifying their partners of their possible exposures. http://www.cdc.gov/nchhstp/partners/Recommendations.html
[9]D-Up: Funding needs to be secured outside of DHEC to fully support the intervention budget. This intervention is costly, approx. $200,000/year; needs program-specific staff dedicated solely to it who are properly trained & understand the population being served.
[10]CTR Services include: ▪ Clinic-based testing offered in DHEC health departments' clinics and routine health care settings including hospital emergency departments. ▪ Testing provided through various methodologies, including rapid testing, using a DHEC-approved type of test. • Community-based testing in venues offering access to hard-to-reach, high-risk populations when the setting is aligned with all CDC and DHEC policies/protocols/quality assurance standards. Counselors must allow time to provide pre-post test counseling, administer the test, develop a client-centered risk reduction plan and make referrals. Counseling will be the only chance for some to learn risks and the value of knowing HIV status. • Referrals must be offered to all clients receiving preliminary and confirmed HIV positive test results.
[11]Sister to Sister: (Individual level and group level) The target population for Sister to Sister is sexually active African American women 18-45 years old who have male partners and are attending primary health care clinics (e.g., family planning, women's health reproductive care, etc.). It is recommended that organizations choosing to implement Sister to Sister should ensure the intervention is implemented by specially trained female health care provider(s) who have completed the 1-day training session. Organizations must integrate and use all core intervention materials.
[12]SiHLE: This is an age-defined intervention targeted to **s**exually experienced African American adolescent females ages 14 – 18. Agencies and/or organizations implementing SiHLE should utilize one adult and two peer facilitators who have been trained in the SiHLE curriculum as recommended in the program literature. Due to the cost of this program, agencies should seek outside funding sources. Agencies should have certified counseling staff or a referral source in place for needed services that may be required.
[13]Nia: It is recommended that organizations choosing to implement Nia utilize two facilitators one male and one female who have been trained in Nia.
[14]STRIVE: This intervention is specifically for Hepatitis C (HCV) positive IDUs.
[15]SISTA-adapted for Latinas: A community/cultural assessment must be done to learn about where the women live, their culture, risk behaviors, and other HIV risk factors. Utilize the SISTA Resource Guide for Adapting SISTA for Latinas. Facilitators should: 1) Be trained facilitators in the SISTA curriculum; 2) Be Latina or Hispanic women who are knowledgeable about and can demonstrate cultural competence with the target population and speak the same language and dialect as the population; 3) Be able to create a culturally sensitive environment; 4) Be knowledgeable about HIV transmission and prevention. The intervention may be conducted with heterosexually active Latina/Hispanic women ages 18up; it should maintain the theoretical framework/core elements of SISTA.
Notes on Other Interventions
Safe in the City DVD is recommended for use in STD/HIV clinics with waiting rooms accessible only to adults. The intervention tools (posters, condoms, video) need to be viewed by staff so that they may answer questions from clients. It is encouraged that intervention materials be used as education for sexually active adults with tools from other interventions. Video can be used in VOICES/VOCES.
Capacity Building is also a recommended intervention but is not specific to a population.
Partners in Prevention: This previously recommended intervention has been moved here as a historical reference but is no longer actively recommended for two reasons: 1) The content has not been updated in a very long time; and 2) More current interventions, such as Healthy Relationships and 3MV, are derived from the original PIP intervention and its related prevention research.

Measuring Success

Concrete information about progress is essential to ensure that high quality prevention services are delivered as intended, intended clients receive those services, training and supervision are provided in response to identified needs, and resources are expended judiciously. Collecting process data is often viewed as a time-consuming process. Although everyone is concerned about providing the best possible prevention services to the most people, some people are willing to continue providing services without proven value. Stakeholders and funding providers—from federal policymakers to community planning groups and members of the priority populations—are demanding empirical evidence of what is being done for people living with and at risk for HIV and how well those services work.

Various data collection systems are used in South Carolina. CTR data is obtained from the lab reports that accompanying the test as well as from the CDC HIV Test Form. DHEC uses a CDC-developed, web-based reporting process, *Program Evaluation Monitoring System* (*PEMS*) for reporting ILIs, GLIs, CLIs, CRCS and Outreach. These data collection and evaluation systems are described in more detail in Chapter 8. Additional details can also be found at: http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/monitoring.htm

For information on the *Advancing HIV Prevention* (*AHP*) initiative and more details on the effectiveness of HIV prevention interventions, the following links may be useful:

- CDC's *Advancing HIV Prevention* initiative: http://www.cdc.gov/hiv/topics/prev_prog/AHP/default.htm

- *What Intervention Studies Say About Effectiveness*: http://www.aed.org/Publications/upload/InterventionEffectiveness.pdf